

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12901

12916

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>13hr 50min</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Royal Oak</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>E</u> Last <u>Bentley</u>		4. DATE OF DEATH Month <u>December</u> Day <u>4</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 14, 1913</u>
9. AGE (In years last birthday) <u>43</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Rouse</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>	
17. INFORMANT <u>Charles Bentley (husb)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute peritonitis</u> <u>540.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Perforated gastric ulcer</u> (c) <u>Perforated gastric ulcer</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-4-56</u> , to <u>12-4-56</u> , that I last saw the deceased alive on <u>12-4-56</u> , and that death occurred at <u>10:20 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Donald F. Bartley</u> M.D.		ADDRESS (Street, city or town, state) <u>9 N. Howard St. Easton, Md.</u>	
DATE SIGNED <u>12-4-56</u>			
PHYSICIAN'S NAME (Type) <u>DONALD F. BARTLEY M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/9/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Richards</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. B. Johnson</u>		ADDRESS <u>Annapolis Md</u>	
24a. REC'D BY REGISTRAR <u>12/8/56</u>		24b. REGISTRAR'S SIGNATURE <u>N. D. Neer</u>	







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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12902

12936

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Trappe</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>Rural Trappe</b>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM A. BRYAN</b>		4. DATE OF DEATH <b>Dec. 6, 1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 6, 1871</b>
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>James Bryan</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-24-2606</b>	
17. INFORMANT <b>Mrs. Ernest Goehringer</b>		Address <b>Hurlock, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterioscl. C.V.D. &amp; fibrillation</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Left thigh amputation for Arterioscl. on 9/4/56</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec. 2, 1956</b> , to <b>Dec. 6, 1956</b> , that I last saw the deceased alive on <b>Dec. 5, 1956</b> , and that death occurred at <b>8:30 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>M. F. Buell</b>		M.D. <b>19 Johns Hopkins Hospital</b> <b>12-10-56</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Martin F. Buell</b>		<b>Easton, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 10, 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oxford Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Oxford, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Maurice E. Newman &amp; Son</b>		ADDRESS <b>Easton, Md.</b>	
24a. REC'D BY REGISTRAR <b>12/10/56</b>		24b. REGISTRAR'S SIGNATURE <b>N. H. Newman</b>	



CERTIFICATE OF DEATH

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
PLACE OF BIRTH [Illegible]		DATE OF BIRTH [Illegible]		TIME OF BIRTH [Illegible]	
PLACE OF DEATH [Illegible]		DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]	
CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]		PLACE OF INTERMENT [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF REGISTRAR [Illegible]		SIGNATURE OF WITNESS [Illegible]	
DATE OF SIGNATURE [Illegible]		DATE OF SIGNATURE [Illegible]		DATE OF SIGNATURE [Illegible]	

BUREAU A. B.

DEC 17 1956

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12917

## CERTIFICATE OF DEATH

12903

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rhodesdale</u> <u>09x-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Franklin</u> Last <u>Carroll</u>				4. DATE OF DEATH Month <u>December</u> Day <u>20</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 6, 1898</u>		9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tossmen</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>State Roads Com.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Wm. Frank Carroll</u>				14. MOTHER'S MAIDEN NAME <u>Rachel Baker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs Margaret P Carroll</u> Address <u>(wife)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>411X</u> DUE TO <u>Acute Stenosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic rheumatic endocarditis</u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 wk</u> <u>(?)</u> <u>(?)</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>12/18</u> , 19 <u>56</u> , to <u>12/20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/20</u> , 19 <u>56</u> , and that death occurred at <u>6:40 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wm. J. Harrison</u> M.D.				ADDRESS (Street, city or town, state) <u>Easton Maryland</u> DATE SIGNED <u>26 Dec 56</u>			
PHYSICIAN'S NAME (Type) <u>HURSTON HARRISON</u>				<u>EASTON MARYLAND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/13/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Shell Crest</u>		22d. LOCATION (City, town, or county) (State) <u>Federalburg Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Frampton Son, Federalburg Md.</u>				24a. REC'D BY REGISTRAR DATE <u>12/23/56</u>		24b. REGISTRAR'S SIGNATURE <u>N. S. Neeris</u>	



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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12918

## CERTIFICATE OF DEATH

12904

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Eastern Talbot Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Annes</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchill, RFD</u>	
c. LENGTH OF STAY IN 1b <u>56 hrs.</u>		d. STREET ADDRESS <u>17X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Girl</u> Last <u>Clough</u>		4. DATE OF DEATH Month <u>December</u> Day <u>19</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 17, '56</u>
9. AGE (In years last birthday) yrs. <u>1</u> Months <u>1</u> Days <u>56</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Easton</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Mr. Walter Clough</u>	
14. MOTHER'S MAIDEN NAME <u>Esther M. Thompson</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother Mrs. Esther Clough</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> 1 <sup>st</sup> 6 <sup>g</sup> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Atelectasis</u> DUE TO (c) <u>Cerebral Hemorrhage</u>		INTERVAL BETWEEN ONSET AND DEATH <u>58 hrs</u> <u>58 hrs</u> <u>58 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>12-17</u> , 19 <u>56</u> to <u>12-19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12-19</u> , 19 <u>56</u> , and that death occurred at <u>9 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John E. Baybutt</u> M.D.		ADDRESS (Street, city or town, state) <u>205 Park Ave Easton, Md 21828</u>	
DATE SIGNED <u>12-22-56</u>		DATE SIGNED <u>12-22-56</u>	
PHYSICIAN'S NAME (Type) <u>John E. Baybutt</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Dec 22 -</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Church Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Church Hill Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>		ADDRESS <u>Church Hill</u>	
24a. REC'D BY REGISTRAR <u>12/22/56</u>		24b. REGISTRAR'S SIGNATURE <u>N.R. Neuman</u>	



BUREAU V.

RECEIVED



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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12919

## CERTIFICATE OF DEATH

12905

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland.</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>8 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalburg.</u> 05 X-2 d. STREET ADDRESS <u>301 W. Cent. above</u>	
3. NAME OF DECEASED (Type or print) First <u>Kenneth</u> Middle <u>V</u> Last <u>Cockran</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>13</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 18, 1892</u> 64 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brick mason</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SAME</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ben F. Cockran</u>		14. MOTHER'S MAIDEN NAME <u>Martha Andrew</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Virginia C. White, wife</u>		Address <u>Federalburg, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> <u>4.20.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary occlusion</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pericardial embolism</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>6.05 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u>		ADDRESS (Street, city or town, state) <u>2195 Washington St. Federalburg, Md.</u>	
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u>		DATE SIGNED <u>13 Dec 56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>12/16/1956</u>		22b. DATE THEREOF <u>12/16/1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Albans Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Federalburg, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Stewart Williams</u>		ADDRESS <u>Federalburg, Md.</u>	
24a. REC'D BY REGISTRAR <u>12/16/56</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Newell</u>	



BUREAU V. J.

DEC 20 1956

RECEIVED



12920

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>The memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Melvin</u> Middle <u>Curtis</u> Last <u>Collins</u>				4. DATE OF DEATH Month <u>12</u> Day <u>24</u> Year <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/20/32</u>	
9. AGE (In years last birthday) <u>24</u> yrs.		IF UNDER 1 YEAR Months <u>24</u> Days <u>24</u> Hours <u>24</u> Min. <u>24</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Timber Cutter</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Fred Collins</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Evans</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-28-4911</u>		17. INFORMANT <u>Fred Collins (father)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple pulmonary emboli</u> 415X DUE TO <u>Cardiac failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO <u>Rheumatic myocarditis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u>				DATE SIGNED <u>26 Dec 56</u>			
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>				ADDRESS <u>Easton 16, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/28/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cokesbury</u>		22d. LOCATION (City, town, or county) (State) <u>near Federalsburg Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Frampton Son, Federalsburg Md</u>				24a. REC'D BY REGISTRAR DATE <u>12/28/56</u>		24b. REGISTRAR'S SIGNATURE <u>N.D. Heer</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

WESTLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF DECEASED</p>	
<p>13. SIGNATURE OF WITNESSES</p>		<p>14. SIGNATURE OF PHYSICIAN</p>		<p>15. SIGNATURE OF CORONER</p>		<p>16. SIGNATURE OF JURY</p>	
<p>17. SIGNATURE OF DECEASED</p>		<p>18. SIGNATURE OF WITNESSES</p>		<p>19. SIGNATURE OF PHYSICIAN</p>		<p>20. SIGNATURE OF CORONER</p>	
<p>21. SIGNATURE OF DECEASED</p>		<p>22. SIGNATURE OF WITNESSES</p>		<p>23. SIGNATURE OF PHYSICIAN</p>		<p>24. SIGNATURE OF CORONER</p>	
<p>25. SIGNATURE OF DECEASED</p>		<p>26. SIGNATURE OF WITNESSES</p>		<p>27. SIGNATURE OF PHYSICIAN</p>		<p>28. SIGNATURE OF CORONER</p>	
<p>29. SIGNATURE OF DECEASED</p>		<p>30. SIGNATURE OF WITNESSES</p>		<p>31. SIGNATURE OF PHYSICIAN</p>		<p>32. SIGNATURE OF CORONER</p>	
<p>33. SIGNATURE OF DECEASED</p>		<p>34. SIGNATURE OF WITNESSES</p>		<p>35. SIGNATURE OF PHYSICIAN</p>		<p>36. SIGNATURE OF CORONER</p>	
<p>37. SIGNATURE OF DECEASED</p>		<p>38. SIGNATURE OF WITNESSES</p>		<p>39. SIGNATURE OF PHYSICIAN</p>		<p>40. SIGNATURE OF CORONER</p>	
<p>41. SIGNATURE OF DECEASED</p>		<p>42. SIGNATURE OF WITNESSES</p>		<p>43. SIGNATURE OF PHYSICIAN</p>		<p>44. SIGNATURE OF CORONER</p>	
<p>45. SIGNATURE OF DECEASED</p>		<p>46. SIGNATURE OF WITNESSES</p>		<p>47. SIGNATURE OF PHYSICIAN</p>		<p>48. SIGNATURE OF CORONER</p>	
<p>49. SIGNATURE OF DECEASED</p>		<p>50. SIGNATURE OF WITNESSES</p>		<p>51. SIGNATURE OF PHYSICIAN</p>		<p>52. SIGNATURE OF CORONER</p>	
<p>53. SIGNATURE OF DECEASED</p>		<p>54. SIGNATURE OF WITNESSES</p>		<p>55. SIGNATURE OF PHYSICIAN</p>		<p>56. SIGNATURE OF CORONER</p>	
<p>57. SIGNATURE OF DECEASED</p>		<p>58. SIGNATURE OF WITNESSES</p>		<p>59. SIGNATURE OF PHYSICIAN</p>		<p>60. SIGNATURE OF CORONER</p>	
<p>61. SIGNATURE OF DECEASED</p>		<p>62. SIGNATURE OF WITNESSES</p>		<p>63. SIGNATURE OF PHYSICIAN</p>		<p>64. SIGNATURE OF CORONER</p>	
<p>65. SIGNATURE OF DECEASED</p>		<p>66. SIGNATURE OF WITNESSES</p>		<p>67. SIGNATURE OF PHYSICIAN</p>		<p>68. SIGNATURE OF CORONER</p>	
<p>69. SIGNATURE OF DECEASED</p>		<p>70. SIGNATURE OF WITNESSES</p>		<p>71. SIGNATURE OF PHYSICIAN</p>		<p>72. SIGNATURE OF CORONER</p>	
<p>73. SIGNATURE OF DECEASED</p>		<p>74. SIGNATURE OF WITNESSES</p>		<p>75. SIGNATURE OF PHYSICIAN</p>		<p>76. SIGNATURE OF CORONER</p>	
<p>77. SIGNATURE OF DECEASED</p>		<p>78. SIGNATURE OF WITNESSES</p>		<p>79. SIGNATURE OF PHYSICIAN</p>		<p>80. SIGNATURE OF CORONER</p>	
<p>81. SIGNATURE OF DECEASED</p>		<p>82. SIGNATURE OF WITNESSES</p>		<p>83. SIGNATURE OF PHYSICIAN</p>		<p>84. SIGNATURE OF CORONER</p>	
<p>85. SIGNATURE OF DECEASED</p>		<p>86. SIGNATURE OF WITNESSES</p>		<p>87. SIGNATURE OF PHYSICIAN</p>		<p>88. SIGNATURE OF CORONER</p>	
<p>89. SIGNATURE OF DECEASED</p>		<p>90. SIGNATURE OF WITNESSES</p>		<p>91. SIGNATURE OF PHYSICIAN</p>		<p>92. SIGNATURE OF CORONER</p>	
<p>93. SIGNATURE OF DECEASED</p>		<p>94. SIGNATURE OF WITNESSES</p>		<p>95. SIGNATURE OF PHYSICIAN</p>		<p>96. SIGNATURE OF CORONER</p>	
<p>97. SIGNATURE OF DECEASED</p>		<p>98. SIGNATURE OF WITNESSES</p>		<p>99. SIGNATURE OF PHYSICIAN</p>		<p>100. SIGNATURE OF CORONER</p>	

BUREAU V. S.

RECEIVED

1955



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12937

## CERTIFICATE OF DEATH

12907

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Oxford</u> <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Oxford</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxford</u>				c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oxford</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Thomas</u> First <u>Edgar</u> Middle <u>Edwards</u> Last				4. DATE OF DEATH <u>December</u> Month <u>29</u> Day <u>1956</u> Year			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Color</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 27, 1874</u>		9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Butler</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Edwards</u>				14. MOTHER'S MAIDEN NAME <u>Mary Edwards</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Sophie Edwards</u>		Address <u>Oxford, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>591X</u> <u>Acute parenchymatous degeneration</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>1 mo.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec. 1</u> , 19 <u>56</u> , to <u>Dec. 29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec. 29</u> , 19 <u>56</u> , and that death occurred at <u>7:25</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>633 Herbert St. East, Md.</u>							
ACTUAL SIGNATURE <u>Hayward T. With</u>		M.D.		DATE SIGNED <u>1/2/57</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-2-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oxford</u>		22d. LOCATION (City, town, or county) (State) <u>Oxford, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Dashiell</u>				ADDRESS <u>Easton</u>		24a. REC'D BY REGISTRAR DATE <u>1/2/57</u>	
						24b. REGISTRAR'S SIGNATURE <u>N.A. Neenan</u>	



# CERTIFICATE OF DEATH

BUREAU V. 8

JAN 8 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12908

12921

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH o. COUNTY <u>Talbot Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>24 Talbot Lane</u>			
3. NAME OF DECEASED (Type or print) <u>MARY Rosetta (Etta) Greenbank</u> Middle Last				4. DATE OF DEATH Month <u>12</u> Day <u>24</u> Year <u>1952</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 31, 1881</u> 74 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Levi George Turpin</u>				14. MOTHER'S MAIDEN NAME <u>Ellen E. Greenbank</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>584X</u>		17. INFORMANT <u>Mr. John H. Greenbank (husb)</u> Address <u>219 S. Westminister St. Easton Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cholecystitis</u> <u>584X</u> DUE TO <u>Cholelithiasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Obesity</u> DUE TO (c) <u>Obesity</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>12:04 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E. C. H. Schmidt</u> M.D.				ADDRESS (Street, city or town, state) <u>219 S. Westminister St. Easton Md.</u>			
DATE SIGNED <u>24 Dec 56</u>							
PHYSICIAN'S NAME (Type) <u>E. C. H. Schmidt</u> <u>Easton 16, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/24/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. E. Nelson</u> ADDRESS <u>Easton Md.</u>				24a. REC'D BY REGISTRAR DATE <u>12/24/56</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Neerick</u>	



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1956



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INSTRUCTIONS  
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.  
VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12909

# CERTIFICATE OF DEATH

12922

Reg. Dist. No. 290

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <b>Talbot</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY <b>Talbot</b>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Easton</b>	LENGTH OF STAY (in this place) <b>50 yrs</b>	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Easton,</b>	<b>40</b>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>20 Glenwood Avenue</b>		STREET ADDRESS (If rural give location) <b>20 Glenwood Avenue</b>	
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>Albert James Haddock</b>		<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>Dec. 14, 1956</b>	
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Married</b>	<b>8. DATE OF BIRTH</b> <b>Oct. 22, 1887</b>
<b>9. AGE last birthday</b> <b>69</b> yrs.		<b>10. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Janitor</b>	
<b>11. BIRTHPLACE</b> (State or foreign country) <b>Delaware</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>James Haddock</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary Mitchell</b>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>	
<b>17. INFORMANT &amp; ADDRESS</b> <b>Mrs. Lena Haddock, 20 Glenwood Ave. Easton, Maryland</b>			
<b>18. MEDICAL CERTIFICATION</b>			<b>INTERVAL BETWEEN ONSET AND DEATH</b>
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>			
<b>420.0 IMMEDIATE CAUSE (A)</b> <b>Arteriosclerotic Heart Disease</b>			<b>3 yrs</b>
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>	
<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>	
<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>	
<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from....., 1954, to 12/14/1956, that I last saw the deceased alive on 12/11/1956, and that death occurred at 7:22 P.M. from the causes and on the date stated above.</b>			
<b>SIGNATURE</b> <b>B. L. Carroll</b>		<b>ADDRESS (Street, city, town, state)</b> <b>Easton, Md</b>	
<b>DATE</b> <b>12/17/56</b>		<b>DATE SIGNED</b> <b>12/17/56</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>24. REC'D BY REGISTRAR</b> <b>Dec. 17 '56 Spring Hill Cemetery Easton, Maryland</b>	
<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>W. Hampton Carroll</b>		<b>26. ADDRESS</b> <b>Easton, Md</b>	



# CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PLACE OF DEATH

10. TIME OF DEATH

11. SIGNATURE OF DECEASED

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF CORONER

15. SIGNATURE OF JUDGE

16. SIGNATURE OF CLERK

17. SIGNATURE OF NOTARY

18. SIGNATURE OF REGISTRAR

19. SIGNATURE OF VICE REGISTRAR

20. SIGNATURE OF ASSISTANT REGISTRAR

21. SIGNATURE OF DEPUTY REGISTRAR

22. SIGNATURE OF CLERK

23. SIGNATURE OF NOTARY

24. SIGNATURE OF REGISTRAR

25. SIGNATURE OF VICE REGISTRAR

26. SIGNATURE OF ASSISTANT REGISTRAR

27. SIGNATURE OF DEPUTY REGISTRAR

28. SIGNATURE OF CLERK

29. SIGNATURE OF NOTARY

BUREAU V. S.

DEC 27 1956

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NOTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

tem 18 Film 209 1-16-57 ams

Item 9 Film 210 2-13-57 et

CERTIFICATE OF DEATH

12910

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> <b>MARYLAND</b> <b>12 Higgins St.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>12 Higgins St.</b>		d. STREET ADDRESS <b>12 Higgins</b>	
3. NAME OF DECEASED (Type or print) <b>Clarence James Edward Hall</b>		4. DATE OF DEATH Month <b>December</b> Day <b>31</b> Year <b>1956</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Color</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 22, 1903</b>
9. AGE (In years last birthday) <b>53</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Maryland</b>	
13. FATHER'S NAME <b>James Woolford</b>		14. MOTHER'S MAIDEN NAME <b>Annie Hall</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Address</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>A. I. D.</b> <b>420.0</b> DUE TO <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7-13-56</b> , 19 <b>56</b> , to <b>12-31-56</b> , 19 <b>56</b> that I last saw the deceased alive on <b>12-11-56</b> , 19 <b>56</b> , and that death occurred at <b>7 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Easton Md</b> DATE SIGNED _____ ACTUAL SIGNATURE <b>[Signature]</b> M.D. _____ PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-3-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Kvytown Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Easton Rt 4, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James B. Dashiell</b>		24a. REC'D BY REGISTRAR DATE <b>1-3-57</b>	
24b. REGISTRAR'S SIGNATURE <b>N. J. Newer</b>			



CERTIFICATE OF DEATH

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12924

CERTIFICATE OF DEATH

Items 8 & 9, Film G209, 1/7/57

Reg. Dist. No. 12942

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>40 Easton</u>		c. LENGTH OF STAY IN 1b <u>9 hr.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>Denton</u>	
3. NAME OF DECEASED (Type or print) First <u>Charlie</u> Middle <u>Hines</u> Last <u>Hines</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>23</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 1, 1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>66</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Hines</u>		14. MOTHER'S MAIDEN NAME <u>Mary Nickol</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Clonza Hines (brother)</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary asphyxiation</u> <u>355x</u> DUE TO <u>Arterial stroke</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. ft. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 8:10 A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u>		ADDRESS (Street, city or town, state) <u>219 S Westington St. Denton, MD</u>	
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>		DATE SIGNED <u>24 Dec 56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>	22b. DATE THEREOF <u>Dec 26</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>	22d. LOCATION (City, town, or county) (State) <u>Denton MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. V. Moore &amp; Son</u>		ADDRESS <u>Denton</u>	
24a. REC'D BY REGISTRAR <u>DATE 12/26/56</u>		24b. REGISTRAR'S SIGNATURE <u>N.H. Newlin</u>	



DEC 31 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12939

CERTIFICATE OF DEATH

Reg. Dist. No.

12913

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Michaels</u>			
c. LENGTH OF STAY IN 1b <u>Life</u>				d. STREET ADDRESS <u>108 Mitchell</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>108 Mitchell St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ely</u> Middle <u>mae</u> Last <u>Kirby</u>				4. DATE OF DEATH Month <u>12</u> Day <u>2</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Col</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/13/187</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oyster Factory</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Gates</u>				14. MOTHER'S MAIDEN NAME <u>Henrietta</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>317-09-9289</u>		17. INFORMANT Address <u>Mrs Helen Bennett, St. Michaels</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of stomach</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>2 mon</u> <u>Common</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/19/56</u> , 1956, to <u>2 December 1956</u> , that I last saw the deceased alive on <u>1 December 1956</u> , and that death occurred at <u>5:20 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>K. Lanele Roth</u>				ADDRESS (Street, city or town, state) <u>Box 487 St. Michaels, Md.</u>			
DATE SIGNED <u>3 Dec 56</u>							
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/5/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>12</u>		22d. LOCATION (City, town, or county) (State) <u>St. Michaels Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Adell, Canton, Md.</u>				24a. REC'D BY REGISTRAR <u>5</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. L. B. Roth</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12925

## CERTIFICATE OF DEATH

12914

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. LENGTH OF STAY IN 1b <u>12 hr.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>				d. STREET ADDRESS <u>Concord Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Baby Boy Kubler (A)</u>				4. DATE OF DEATH <u>Dec. 19 1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 18</u>	9. AGE (In years last birthday) yrs. <u>12</u>	IF UNDER 1 YEAR Months <u>12</u> Days <u>5</u>	IF UNDER 24 HRS. Hours <u>12</u> Min. <u>5</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Paul Ira Kubler</u>				14. MOTHER'S MAIDEN NAME <u>Peggy Ellen Ireland</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT <u>Mr Paul Kubler</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Petechial ecchymosis.</u> 774X DUE TO <u>Prematurity.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Baltimore</u> , 19 <u>56</u> , to <u>1956</u> , that I last saw the deceased alive on <u>12</u> , 19 <u>56</u> , and that death occurred at <u>1:30</u> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u> M.D.				ADDRESS (Street, city or town, state) <u>219 S. Washington St</u> DATE SIGNED <u>20 Dec 1956</u>			
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>				Canton 16, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 20 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. A. ...</u> ADDRESS <u>Easton</u>				24a. REC'D BY REGISTRAR <u>2/20/56</u>		24b. REGISTRAR'S SIGNATURE <u>N. A. ...</u>	



CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH							
FATHER'S NAME		MOTHER'S NAME		MARRIED		SINGLE		WIDOWED		DIVORCED		SEPARATED		RECEIVED		RECEIVED		RECEIVED		RECEIVED		RECEIVED		RECEIVED		RECEIVED		RECEIVED		RECEIVED							
OCCUPATION		EDUCATION		RELIGION		POLITICAL PARTY		MILITARY SERVICE		MILITARY RANK		MILITARY BRANCH		MILITARY DUTY		MILITARY DUTY		MILITARY DUTY		MILITARY DUTY		MILITARY DUTY		MILITARY DUTY		MILITARY DUTY		MILITARY DUTY		MILITARY DUTY							
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	

BUREAU V. S.

DEC 27 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12915

12926

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Corrova</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial Hospital</u>		d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Baby Boy Kubler (B)</u>		4. DATE OF DEATH <u>December 20 19 56</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC 18</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>21 34</u>
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Paul Ira Kubler</u>		14. MOTHER'S MAIDEN NAME <u>Peggy E. Ireland</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Peggy E. Kubler</u>		Address <u>Corrova, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Foetal Anoxia</u> <u>762.5</u> DUE TO <u>Prematurity</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>5:20 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E.C.H. Schmidt</u> M.D.		ADDRESS (Street, city or town, state) <u>219 S. Washington St. 20 Dec 56</u>	
PHYSICIAN'S NAME (Type) <u>E.C.H. Schmidt</u>		DATE SIGNED <u>20 Dec 56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec 20, 56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>	22d. LOCATION (City, town or county) (State) <u>Easton 16, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. B. Easton</u> ADDRESS		24a. REC'D BY REGISTRAR <u>DATE 12/20/56</u>	24b. REGISTRAR'S SIGNATURE <u>N.H. Newrick</u>

1200182XVI



CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
MILAN		M		30		JAN 1 1910		BALTIMORE, MARYLAND	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE	
CLOCK REPAIRER		HIGH SCHOOL		MARRIED		METHODIST		WHITE	
CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		PLACE OF DEATH		DATE OF DEATH	
HEART DISEASE		NATURAL		3 WEEKS		HOME		DEC 15 1956	
IMMEDIATE CAUSE		MIDDLE CAUSE		FUNDAMENTAL CAUSE		DATE OF EXAMINATION		PLACE OF EXAMINATION	
CORONARY ARTERY DISEASE		HYPERTENSION		HEART DISEASE		DEC 15 1956		HOME	
SIGNS AND SYMPTOMS		TREATMENT		DIAGNOSIS		PROGNOSIS		REMARKS	
PAIN IN CHEST		ASPIRIN		MYOCARDIAL INFARCTION		POOR		NO POSTMORTEM	
DYSNOEA		OXYGEN		CORONARY ARTERY DISEASE		POOR		NO POSTMORTEM	
FATIGUE		REST		CORONARY ARTERY DISEASE		POOR		NO POSTMORTEM	
LOSS OF APPETITE		DIET		CORONARY ARTERY DISEASE		POOR		NO POSTMORTEM	
WEIGHT LOSS		NUTRITION		CORONARY ARTERY DISEASE		POOR		NO POSTMORTEM	
PALLOR		HYDRATION		CORONARY ARTERY DISEASE		POOR		NO POSTMORTEM	
TENDENCY TO BLEED		COAGULATION		CORONARY ARTERY DISEASE		POOR		NO POSTMORTEM	
FAMILY HISTORY		SOCIAL HISTORY		HISTORICAL DATA		PHYSICAL DATA		LABORATORY DATA	
NONE		NONE		NONE		NONE		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE		TIME		PLACE		CITY		STATE	
DEC 15 1956		10:00 AM		HOME		BALTIMORE		MARYLAND	

BUREAU V.

DEC 27 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12927

## CERTIFICATE OF DEATH

12916

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>12 hrs 40 min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greensboro</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Memorial</u>				d. STREET ADDRESS <u>None</u>			
3. NAME OF DECEASED (Type or print) First <u>Benjamin</u> Middle <u>Leroy</u> Last <u></u>				4. DATE OF DEATH Month <u>12</u> Day <u>28</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 3, 1887</u>		9. AGE (In years last birthday) <u>69</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer Lumber Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>No Record</u>				14. MOTHER'S MAIDEN NAME <u>No Record</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Robert Boyd</u> Address <u>Greensboro, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>294X</u> DUE TO <u>Mesenteric Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Polycythemia Rubra Vera</u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>12/27/1956</u> , to <u>12/28/1956</u> that I last saw the deceased alive on <u>12/28/1956</u> , and that death occurred at <u>6:00 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>Easton Md</u>				PHYSICIAN'S NAME (Type) <u></u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/30/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>		22d. LOCATION (City, town, or county) (State) <u>Greensboro Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. G. Boulaie</u> ADDRESS <u>Greensboro Md</u>				24a. REC'D BY REGISTRAR <u>12/30/56</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Newsum</u>	



CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
OCCUPATION		EDUCATION		MARRIAGE		RELIGION		SOCIETY		POLITICAL PARTY		MILITARY SERVICE		NAVY SERVICE		AIR FORCE SERVICE		MARINE SERVICE		ARMY SERVICE		NAVY SERVICE		AIR FORCE SERVICE		MARINE SERVICE	
CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS INJURY		PREVIOUS DISEASE		PREVIOUS TREATMENT		PREVIOUS MEDICATION		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS INJURY		PREVIOUS DISEASE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF JURY		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN		SIGNATURE OF MINISTER		SIGNATURE OF CHURCH		SIGNATURE OF FUNERAL HOME		SIGNATURE OF BURIAL PLACE		SIGNATURE OF CEMETERY		SIGNATURE OF INTERMENT		SIGNATURE OF CREMATION		SIGNATURE OF REINTERMENT	

BUREAU V. 2

JAN 8 1957

RECEIVED



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Frederick</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Goldstboro</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Henry</u> Last <u>Mary</u>		4. DATE OF DEATH Month <u>12</u> Day <u>12</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>38</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>John Robert Mary</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Etta Hostler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Margaret Mary - Goldstboro Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suppurative Gastric Hemorrhage</u> DUE TO <u>3rd degree Burns Peritonitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gun Shot Wound</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>12-7-56</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, store, office bldg., etc.) <u>Road</u>	20f. (City or town) <u>Goldstboro</u> (County) <u>Carroll</u> (State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Dawson O George</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>12/15/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Union</u>	22d. LOCATION (City, town, or county) (State) <u>Goldstboro Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J.E. Boulaie</u>		24a. REC'D BY REGISTRAR <u>N.A. Neerix</u>	
ADDRESS <u>Greensboro Md.</u>		24b. REGISTRAR'S SIGNATURE	
		DATE <u>12/15/56</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



DEC 29 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12918

## 12940 CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH o. COUNTY <b>Talbot</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Easton</b>		c. LENGTH OF STAY IN 1b <b>30 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>Rural Easton</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>BARBARA F. NEWBAKER</b>		4. DATE OF DEATH Month Day Year <b>December 10, 1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 8, 1907</b>
9. AGE (In years last birthday) <b>49</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Philadelphia, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Alexander Fergusson</b>		14. MOTHER'S MAIDEN NAME <b>Mable Carter</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Theodore Phillips</b>		Address <b>Cambridge, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Hemorrhage</b> 443X DUE TO (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c) <b>6 years</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1/10, 1949</b> , to <b>Jan</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>Aug 1, 1956</b> , and that death occurred at <b>10:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Shepherd Krech, Jr.</b>		ADDRESS (Street, city or town, state) <b>Easton, Md</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Shepard Krech, Jr.</b>		DATE SIGNED <b>12/11/56</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>Dec. 12, 1956</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Silverbrook Cemetery Crem.</b>		22d. LOCATION (City, town, or county) (State) <b>Wilmington, Delaware</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Maurice E. Newnam &amp; Son</b>		24a. REC'D BY REGISTRAR <b>12/12/56</b>	
ADDRESS <b>Easton, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>M. A. Newnam</b>	



BUREAU V. S.

DEC 20 1955

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12919

12941

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tilghman</u>			c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tilghman</u> X		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>/</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Oscar H. Page</u>				4. DATE OF DEATH Month Day Year <u>12 21 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-9-1884</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery Store</u>		11. BIRTHPLACE (State or foreign country) <u>Tilghman, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Frank R. Page</u>		14. MOTHER'S MAIDEN NAME <u>Sarah J. Harrison</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-07-9321</u>		17. INFORMANT Address <u>Mrs. Oscar Page - Tilghman, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>5 pm</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1935</u> to <u>Dec 21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Dec 21</u> , 19 <u>56</u> , and that death occurred at <u>5:40</u> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>GUY M REESER Sr</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Tilghman Md Dec 23 1956</u>			
22a. BURIAL, CREMATION, REMOVAL <u>Burial</u>		22b. DATE THEREOF <u>12-23-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Tilghman Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Tilghman Talbot Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Tilghman</u>				ADDRESS <u>Tilghman</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 27 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Miss K. L. K. K.</u>							



CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Faint text]</p>		<p>2. SEX [Faint text]</p>	
<p>3. AGE [Faint text]</p>		<p>4. DATE OF BIRTH [Faint text]</p>	
<p>5. PLACE OF BIRTH [Faint text]</p>		<p>6. OCCUPATION [Faint text]</p>	
<p>7. MARITAL STATUS [Faint text]</p>		<p>8. CAUSE OF DEATH [Faint text]</p>	
<p>9. MEDICAL HISTORY [Faint text]</p>		<p>10. DATE OF DEATH [Faint text]</p>	
<p>11. PLACE OF DEATH [Faint text]</p>		<p>12. SIGNATURE OF PHYSICIAN [Faint text]</p>	
<p>13. SIGNATURE OF REGISTRAR [Faint text]</p>		<p>14. DATE OF REGISTRATION [Faint text]</p>	

BUREAU V. SS.

DEC 27 1956

RECEIVED



12942

## CERTIFICATE OF DEATH

Reg. Dist. No. 291

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MICHAELS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MICHAELS</u>			
c. LENGTH OF STAY IN 1b <u>LIFE</u>				d. STREET ADDRESS <u>MILL STREET</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>NORA V. PINKETT</u>				4. DATE OF DEATH Month Day Year <u>Dec 7 1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>COLORED</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 1, 1895</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>GENERAL</u>		11. BIRTHPLACE (State or foreign country) <u>ST. MICHAELS MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>ANDREW BARNETT</u>		14. MOTHER'S MAIDEN NAME <u>BERTHA JOHNSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT Address <u>PAGE PINKETT, ST. MICHAELS MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma - generalized</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of breast</u> DUE TO (c) <u>4 years</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>2 Jan</u> , 19 <u>56</u> , to <u>7 Dec</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>6 Dec</u> , 19 <u>56</u> , and that death occurred at <u>7:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. Lane Wraith</u> M.D.				ADDRESS (Street, city or town, state) <u>St Michaels, Md</u>			
DATE SIGNED <u>8 Dec 56</u>							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 10, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Thomas Memorial Bury</u>		22d. LOCATION (City, town, or county) (State) <u>St Michaels Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Hampton Harrison</u>				ADDRESS <u>St. Michaels, Md</u>		24a. REC'D BY REGISTRAR <u>DATE 12-10-56</u>	
24b. REGISTRAR'S SIGNATURE <u>Mr Robert L. Seth</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		MANNER OF DEATH	
AGE		SEX	
RACE		EDUCATION	
OCCUPATION		MARITAL STATUS	
PREVIOUS ILLNESS		CAUSE OF DEATH	
IMMEDIATE CAUSE		MEDICAL HISTORY	
PATHOLOGICAL FINDINGS		LABORATORY TESTS	
TREATMENT		POST-MORTEM	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR	
DATE OF SIGNATURE		PLACE OF SIGNATURE	

BUREAU V. S.

DEC 11 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12929

## CERTIFICATE OF DEATH

12921

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>Susie</u> Middle <u>Ross</u> Last <u>Ross</u>				4. DATE OF DEATH Month <u>12</u> - Day <u>2</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 8, 1869</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Thomas H Brinsfield</u>				14. MOTHER'S MAIDEN NAME <u>Mary Rebecca Perrot</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mrs Va (Hughlett) Easton</u>		Address <u>416 Trappe Rd</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Coronary Disease</u> DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>12/1/1956</u> to <u>12/2/1956</u> , that I last saw the deceased alive on <u>12/2/1956</u> , and that death occurred at <u>9:05</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. B. Cox</u>				M.D. <u>Easton md</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 5, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Maurice E. Newman</u>				ADDRESS <u>500 Easton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>12/5/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>N. H. Neekens</u>			



CERTIFICATE OF DEATH

DATE OF DEATH		PLACE OF DEATH	
TIME OF DEATH		CAUSE OF DEATH	
AGE		SEX	
RACE		OCCUPATION	
BIRTH DATE		BIRTH PLACE	
MARRIAGE DATE		MARRIAGE PLACE	
EDUCATION		RELIGION	
PREVIOUS ILLNESS		TREATMENT	
DATE OF BURIAL		PLACE OF BURIAL	
NAME OF FUNERAL HOME		NAME OF MINISTER	
NAME OF WITNESSES		NAME OF PHYSICIAN	
SIGNATURE OF REGISTRAR		SIGNATURE OF PHYSICIAN	
DATE OF REGISTRATION		PLACE OF REGISTRATION	

BUREAU V. R.

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1  
INSTRUCTIONS  
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 14 Film 208 12-17-56 et

12922

12943  
CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Talbot</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Talbot</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Rural Cordova</u>		<u>52 yrs.</u>		TOWN <u>Rural Cordova</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Diedrich Sander.</u>				<u>12/1/56</u> 19 <u>56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>W</u>	<u>Married</u>	<u>Jan. 12, 1866</u>	<u>90</u> yrs.	Months <u>11</u>	Days <u>19</u>	Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Farmer</u>		<u>own farm</u>		<u>Germany</u>		<u>U. S</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Herman Sander.</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>none</u>		<u>Mrs. D. Sander. Cordova.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				<u>2 weeks -</u>			
IMMEDIATE CAUSE (A) <u>pyelonephritis &amp; toxemia</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized Arterio sclerosis</u>				<u>1 year</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>none</u>		<u>none</u>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-1</u> , 19 <u>56</u> , to <u>12-1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11-30</u> , 19 <u>56</u> , and that death occurred at <u>3:20</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>William L. Winters</u>				DATE SIGNED <u>12/3/56</u>			
M.D. <u>Easton Maryland</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Dec. 3, 56</u>		<u>Spring Hill</u>		<u>Easton, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>12/3/56</u>		<u>N.A. Neerius</u>		<u>Wm. L. Winters</u>		<u>Easton Md.</u>	



# CERTIFICATE OF DEATH

1956

1. NAME OF DECEASED (Print Name)

2. PLACE OF DEATH

3. SEX ( ) Male ( ) Female

4. AGE ( ) Years ( ) Months ( ) Days

5. OCCUPATION

6. DATE OF BIRTH ( ) Year ( ) Month ( ) Day

7. PLACE OF BIRTH

8. MARITAL STATUS ( ) Single ( ) Married ( ) Widowed ( ) Divorced

9. CAUSE OF DEATH ( ) Natural ( ) Accidental ( ) Suicide ( ) Homicide

10. MANNER OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF CLERK

17. SIGNATURE OF JUDGE

18. SIGNATURE OF SHERIFF

19. SIGNATURE OF CONSTABLE

20. SIGNATURE OF JURY

21. SIGNATURE OF GRAND JURY

22. SIGNATURE OF COURT

23. SIGNATURE OF JUDGE

24. SIGNATURE OF SHERIFF

25. SIGNATURE OF CONSTABLE

26. SIGNATURE OF JURY

27. SIGNATURE OF GRAND JURY

28. SIGNATURE OF COURT

29. SIGNATURE OF JUDGE

30. SIGNATURE OF SHERIFF

31. SIGNATURE OF CONSTABLE

32. SIGNATURE OF JURY

33. SIGNATURE OF GRAND JURY

34. SIGNATURE OF COURT

35. SIGNATURE OF JUDGE

36. SIGNATURE OF SHERIFF

37. SIGNATURE OF CONSTABLE

38. SIGNATURE OF JURY

39. SIGNATURE OF GRAND JURY

40. SIGNATURE OF COURT

41. SIGNATURE OF JUDGE

42. SIGNATURE OF SHERIFF

43. SIGNATURE OF CONSTABLE

44. SIGNATURE OF JURY

45. SIGNATURE OF GRAND JURY

46. SIGNATURE OF COURT

47. SIGNATURE OF JUDGE

48. SIGNATURE OF SHERIFF

49. SIGNATURE OF CONSTABLE

50. SIGNATURE OF JURY

51. SIGNATURE OF GRAND JURY

52. SIGNATURE OF COURT

53. SIGNATURE OF JUDGE

54. SIGNATURE OF SHERIFF

55. SIGNATURE OF CONSTABLE

56. SIGNATURE OF JURY

57. SIGNATURE OF GRAND JURY

58. SIGNATURE OF COURT

59. SIGNATURE OF JUDGE

60. SIGNATURE OF SHERIFF

61. SIGNATURE OF CONSTABLE

62. SIGNATURE OF JURY

63. SIGNATURE OF GRAND JURY

64. SIGNATURE OF COURT

65. SIGNATURE OF JUDGE

66. SIGNATURE OF SHERIFF

67. SIGNATURE OF CONSTABLE

68. SIGNATURE OF JURY

69. SIGNATURE OF GRAND JURY

70. SIGNATURE OF COURT

71. SIGNATURE OF JUDGE

72. SIGNATURE OF SHERIFF

73. SIGNATURE OF CONSTABLE

74. SIGNATURE OF JURY

75. SIGNATURE OF GRAND JURY

76. SIGNATURE OF COURT

77. SIGNATURE OF JUDGE

78. SIGNATURE OF SHERIFF

79. SIGNATURE OF CONSTABLE

80. SIGNATURE OF JURY

81. SIGNATURE OF GRAND JURY

82. SIGNATURE OF COURT

83. SIGNATURE OF JUDGE

84. SIGNATURE OF SHERIFF

85. SIGNATURE OF CONSTABLE

86. SIGNATURE OF JURY

87. SIGNATURE OF GRAND JURY

88. SIGNATURE OF COURT

89. SIGNATURE OF JUDGE

90. SIGNATURE OF SHERIFF

91. SIGNATURE OF CONSTABLE

92. SIGNATURE OF JURY

93. SIGNATURE OF GRAND JURY

94. SIGNATURE OF COURT

95. SIGNATURE OF JUDGE

96. SIGNATURE OF SHERIFF

97. SIGNATURE OF CONSTABLE

98. SIGNATURE OF JURY

99. SIGNATURE OF GRAND JURY

100. SIGNATURE OF COURT

101. SIGNATURE OF JUDGE

102. SIGNATURE OF SHERIFF

103. SIGNATURE OF CONSTABLE

104. SIGNATURE OF JURY

105. SIGNATURE OF GRAND JURY

106. SIGNATURE OF COURT

107. SIGNATURE OF JUDGE

108. SIGNATURE OF SHERIFF

109. SIGNATURE OF CONSTABLE

110. SIGNATURE OF JURY

111. SIGNATURE OF GRAND JURY

112. SIGNATURE OF COURT

113. SIGNATURE OF JUDGE

114. SIGNATURE OF SHERIFF

115. SIGNATURE OF CONSTABLE

116. SIGNATURE OF JURY

117. SIGNATURE OF GRAND JURY

118. SIGNATURE OF COURT

119. SIGNATURE OF JUDGE

120. SIGNATURE OF SHERIFF

121. SIGNATURE OF CONSTABLE

122. SIGNATURE OF JURY

123. SIGNATURE OF GRAND JURY

124. SIGNATURE OF COURT

125. SIGNATURE OF JUDGE

BUREAU V. 2

DEC 11 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 13 FilmG209 1-14-57 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

12923  
290

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton Md.</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Goldsboro 05X 2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Easton Memorial Hospital</u>				d. STREET ADDRESS <u>None</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MRS. Elizabeth</u> First <u>Scotten</u> Middle <u>Scotten</u> Last <u>Scotten</u>				4. DATE OF DEATH Month <u>12</u> Day <u>28</u> Year <u>1956</u>			
5. SEX <u>Fe</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 7 1867</u> 89 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>(Unknown) Brown</u>				14. MOTHER'S MAIDEN NAME <u>Brown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Lemuel Scotten, son - Goldsboro, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A.H.D</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. p. _____ p. m. _____ Month _____ Day _____ Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>12/26</u> , 19 <u>56</u> , to <u>12/28</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>12/28/56</u> , 19 <u>56</u> , and that death occurred at <u>2:30</u> P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u>		ADDRESS (Street, city or town, state) <u>Easton Md</u> DATE SIGNED _____					
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/2/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>		22d. LOCATION (City, town, or county) (State) <u>Greensboro Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.G. Boulois</u> ADDRESS <u>Greensboro, Md.</u>				24a. REC'D BY REGISTRAR <u>[Signature]</u> DATE <u>1/2/57</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	



CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. MARITAL STATUS		7. OCCUPATION		8. CAUSE OF DEATH		9. PLACE OF DEATH		10. TIME OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF WITNESS	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12931

## CERTIFICATE OF DEATH

12924  
Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <i>Talbot</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Talbot</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Easton</i> 40	
d. NAME OF HOSPITAL (If not in hospital, give street address); OR INSTITUTION <i>Memorial Hospital</i>		d. STREET ADDRESS <i>218 S. Harrison St.</i>	
3. NAME OF DECEASED (Type or print) First <i>Bella</i> Middle <i>Spannahan</i> Last		4. DATE OF DEATH Month <i>12</i> Day <i>1</i> Year <i>1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 9, 1874</i>
9. AGE (In years last birthday) <i>82</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Arkaska Hardin</i>		14. MOTHER'S MAIDEN NAME <i>Anna Smith</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Miss Lola Hardin (sister)</i>		Address <i>Soulsbury, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Intra cranial Hemorrhage</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <i>5:30 A.M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <i>219 S. Washington St. Dec. 56</i> ACTUAL SIGNATURE <i>E.C.H. Schmidt</i> M.D. <i>Easton, Maryland.</i> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>12/4/56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Easton Md.</i>		22d. LOCATION (City, town, or county) (State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Easton Md.</i>		24a. REC'D BY REGISTRAR DATE <i>12/4/56</i>	
24b. REGISTRAR'S SIGNATURE <i>N. H. Newlin</i>			







## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12944

## CERTIFICATE OF DEATH

Reg. Dist. No.

12925  
290

1. PLACE OF DEATH o. COUNTY <u>Talbot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton Rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Royal Oak, Rural</u>			
c. LENGTH OF STAY IN 1b <u>all x life</u>				d. STREET ADDRESS <u>—</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>E</u> Last <u>Sullivan</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>3</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Black</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan 15 1876</u> 90 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Royal Oak Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Pinkney Bellings</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Bellings</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>214-36-5384</u>				17. INFORMANT <u>James Lomas Easton, Md R.</u> Address <u>—</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>332x Occlusion, left middle cerebral artery</u> DUE TO (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>years</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Jan 1951</u> , to <u>11/22, 1956</u> , that I last saw the deceased alive on <u>11/22, 1956</u> , and that death occurred at <u>6-8</u> M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Shepherd Krech, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Easton, Md</u> DATE SIGNED <u>12/3/56</u>			
PHYSICIAN'S NAME (Type) <u>Shepherd Krech, Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/5/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Pauls Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Easton Rural Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John A Williams</u> ADDRESS <u>Easton, Md.</u>				24. REC'D BY REGISTRAR DATE <u>12/5/56</u>		25. REGISTRAR'S SIGNATURE <u>N.H. Newmyer</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

BUREAU V. 8.

DEC 11 1956

RECEIVED



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 296

1. PLACE OF DEATH a. COUNTY <b>Talbot</b> <b>12932</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b> c. LENGTH OF STAY IN lb <b>5 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg - Rural</b> d. STREET ADDRESS <b>Denton Road</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Dianna</b> Middle <b>Angela</b> Last <b>Taylor</b>		4. DATE OF DEATH Month <b>December</b> Day <b>6</b> Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 21, 1949</b>
9. AGE (In years last birthday) <b>7</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>7</b>	IF UNDER 24 HRS. Hours <b>7</b> Min. <b>7</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Public School</b>	11. BIRTHPLACE (State or foreign country) <b>Federalsburg, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>James Taylor</b>	
14. MOTHER'S MAIDEN NAME <b>Mildred Simms</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mildred Taylor, Federalsburg, Md., R.F.D.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>3rd degree Burns</b> 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>12 1 19 56</b> Hour <b>12</b> o. m. <b>12</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) <b>Federalsburg</b> (County) <b>Caroline</b> (State) <b>MD</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Dawson O. George</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dawson O. George</b>		DATE SIGNED <b>Dec. 6, 1956</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec. 8, 1956</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Saint Paul Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Near Federalsburg, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>J.J. Frampton and Son, Federalsburg, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>12/8/56</b>	24b. REGISTRAR'S SIGNATURE <b>N. H. Newlin</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX _____		AGE _____	
PLACE OF BIRTH _____		OCCUPATION _____		MARITAL STATUS _____	
DATE OF DEATH _____		TIME OF DEATH _____		PLACE OF DEATH _____	
CAUSE OF DEATH _____		MANNER OF DEATH _____		SIGNATURE OF MEDICAL EXAMINER _____	
SIGNATURE OF NEXT OF KIN _____		SIGNATURE OF WITNESS _____		SIGNATURE OF JURY _____	

BUREAU V. S.

DEC 11 1956

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12927

Reg. Dist. No.

12945

1. PLACE OF DEATH a. COUNTY <b>TALBOT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>TALBOT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BELLVUE near</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>ROBERT</b> Middle <b>JAMES</b> Last <b>THOMAS</b>				4. DATE OF DEATH Month <b>DEC</b> Day <b>18</b> Year <b>19 56</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>Col</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN 25 1906</b>		9. AGE (In years last birthday) <b>50 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>shellfish</b>		11. BIRTHPLACE (State or foreign country) <b>Tal.Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Robert Thomas</b>				14. MOTHER'S MAIDEN NAME <b>Annie Roberts</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>220-28-1351</b>		17. INFORMANT <b>Mrs. R.J. Thomas</b>		Address <b>Bellvue Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>G.S.W. abdomen</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Hunting accident</b> (a), stating the underlying cause lost. DUE TO cause lost. (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>minutes--</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>gun caught in briars and discharged into abdomen</b>					
20c. TIME OF INJURY Month, Day, Year <b>c 4 P 12-18 19 56</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>woods near Bellvue Talbot Md</b>		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Louis S. Welty</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>12-19-56</b>	
EXAMINER'S NAME (Type) <b>Louis S. Welty</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>12/23/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Richards Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Easton Md</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>James B. Schell, Easton, Md</b>				24a. REC'D BY REGISTRAR <b>DEC 28 1956</b>		24b. REGISTRAR'S SIGNATURE <b>Mrs. R. J. Thomas</b>	



MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 3

DEC 28 1956

RECEIVED



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12928

12946

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Royal Oak</u>				c. LENGTH OF STAY IN 1b <u>30 min.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton, Maryland</u>			
				d. STREET ADDRESS			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ralph A. Townsend</u>				4. DATE OF DEATH Month Day Year <u>Dec. 12, 1956</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 23, 1897</u>	9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <u>4</u> <u>19</u>		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerical</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Easton Utilities</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Willard T. Townsend</u>				14. MOTHER'S MAIDEN NAME <u>Ida M. Starkey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>215-70-434</u>		17. INFORMANT Address <u>Mrs. R. A. Townsend, Easton,</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction Due to</u> <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour o. ft. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Easton</u>		(County) <u>Talbot</u>		(State) <u>Md.</u>
21. I certify that I attended the deceased from <u>12-12-56</u> , to <u>12-12-56</u> , that I last saw the deceased alive on <u>12-12-56</u> , and that death occurred at <u>7 A</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ronald H. Bartley</u>		M.D. <u>9 N. Hanson St.</u>		ADDRESS (Street, city or town, state) <u>Easton Md</u>		DATE SIGNED <u>12-12-56</u>	
PHYSICIAN'S NAME (Type) <u>Ronald H. Bartley</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec. 15, 56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Easton, Maryland.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Cook</u>				24a. REC'D BY REGISTRAR DATE <u>12/14/56</u>		24b. REGISTRAR'S SIGNATURE <u>N. H. Neer</u>	



CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF DECEASED</p>	
<p>13. SIGNATURE OF WITNESSES</p>		<p>14. SIGNATURE OF PHYSICIAN</p>		<p>15. SIGNATURE OF CORONER</p>		<p>16. SIGNATURE OF JUDGE</p>	
<p>17. SIGNATURE OF CLERK</p>		<p>18. SIGNATURE OF REGISTRAR</p>		<p>19. SIGNATURE OF SHERIFF</p>		<p>20. SIGNATURE OF SHERIFF'S DEPUTY</p>	
<p>21. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>22. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>23. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>24. SIGNATURE OF SHERIFF'S DEPUTY</p>	
<p>25. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>26. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>27. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>28. SIGNATURE OF SHERIFF'S DEPUTY</p>	
<p>29. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>30. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>31. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>32. SIGNATURE OF SHERIFF'S DEPUTY</p>	
<p>33. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>34. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>35. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>36. SIGNATURE OF SHERIFF'S DEPUTY</p>	
<p>37. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>38. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>39. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>40. SIGNATURE OF SHERIFF'S DEPUTY</p>	
<p>41. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>42. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>43. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>44. SIGNATURE OF SHERIFF'S DEPUTY</p>	
<p>45. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>46. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>47. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>48. SIGNATURE OF SHERIFF'S DEPUTY</p>	
<p>49. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>50. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>51. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>52. SIGNATURE OF SHERIFF'S DEPUTY</p>	
<p>53. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>54. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>55. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>56. SIGNATURE OF SHERIFF'S DEPUTY</p>	
<p>57. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>58. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>59. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>60. SIGNATURE OF SHERIFF'S DEPUTY</p>	
<p>61. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>62. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>63. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>64. SIGNATURE OF SHERIFF'S DEPUTY</p>	
<p>65. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>66. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>67. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>68. SIGNATURE OF SHERIFF'S DEPUTY</p>	
<p>69. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>70. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>71. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>72. SIGNATURE OF SHERIFF'S DEPUTY</p>	
<p>73. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>74. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>75. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>76. SIGNATURE OF SHERIFF'S DEPUTY</p>	
<p>77. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>78. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>79. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>80. SIGNATURE OF SHERIFF'S DEPUTY</p>	
<p>81. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>82. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>83. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>84. SIGNATURE OF SHERIFF'S DEPUTY</p>	
<p>85. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>86. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>87. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>88. SIGNATURE OF SHERIFF'S DEPUTY</p>	
<p>89. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>90. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>91. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>92. SIGNATURE OF SHERIFF'S DEPUTY</p>	
<p>93. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>94. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>95. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>96. SIGNATURE OF SHERIFF'S DEPUTY</p>	
<p>97. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>98. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>99. SIGNATURE OF SHERIFF'S DEPUTY</p>		<p>100. SIGNATURE OF SHERIFF'S DEPUTY</p>	

BUREAU V. S.

DEC 17 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12933

## CERTIFICATE OF DEATH

Reg. Dist. No.

12929

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton, md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fruitland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Oldfolks Home Sewells</u>		d. STREET ADDRESS <u>228-2</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Hester Ann Ward</u>		4. DATE OF DEATH Month Day Year <u>12 7 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/16/1876</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Small</u>		14. MOTHER'S MARDEN NAME <u>Milky Maddox</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mr. H. Ward Ridgely, md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Art. Sci</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>day</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-1</u> , 19 <u>50</u> , to <u>12-7</u> , 19 <u>56</u> that I last saw the deceased alive on <u>12-7</u> , 19 <u>56</u> , and that death occurred at <u>6 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W F Buell</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>19 Fielding St Easton md 12-11-56</u>	
PHYSICIAN'S NAME (Type) <u>M. F. Buell MD</u>		<u>Easton Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>12/11/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Denton Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Denton, md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James B. Buel, Easton, md</u>		ADDRESS <u>—</u>	
24a. REC'D BY REGISTRAR <u>DEC 14 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. N. H. Harris</u>	



CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Smith</i>		DATE OF DEATH <i>1-15-56</i>	
AGE <i>45</i>		SEX <i>Male</i>	
RACE <i>White</i>		MARRIAGE <i>Married</i>	
BIRTH <i>1-1-11</i>		PLACE OF BIRTH <i>St. Louis, Mo.</i>	
OCCUPATION <i>Teacher</i>		CAUSE OF DEATH <i>Heart Disease</i>	
DISEASE OR INJURY <i>Myocardial Infarction</i>		PERMANENT DAMAGE <i>None</i>	
PLACE OF DEATH <i>Home</i>		MANNER OF DEATH <i>Natural</i>	
SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>		SIGNATURE OF REGISTRAR <i>John Doe</i>	
DATE OF SIGNATURE <i>1-15-56</i>		DATE OF SIGNATURE <i>1-15-56</i>	

RECEIVED  
DEC 14 1956  
BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12930

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>		c. LENGTH OF STAY IN 1b <u>30 min.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Easton Memorial Hosp.</u>		d. STREET ADDRESS <u>Creamery Lane</u>	
3. NAME OF DECEASED (Type or print) First <u>Jerry</u> Middle <u>D</u> Last <u>Weddle</u>		4. DATE OF DEATH Month <u>12</u> Day <u>22</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 14 1939</u>
9. AGE (In years last birthday) <u>17</u> yrs.		IF UNDER 1 YEAR Months <u>17</u> Days <u>17</u> Hours <u>17</u> Min. <u>17</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Truck Driver</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Theodore Weddle</u>		14. MOTHER'S MAIDEN NAME <u>Stella Alderman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mr Theodore Weddle</u>		Address <u>Easton Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Laceration brain</u> 823X DUE TO (b) <u>Auto accident</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Auto accident</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Driving car which hit trees</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driving car which hit trees</u>	
20c. TIME OF INJURY Month, Day, Year <u>Hour a. m. 12-22 1956</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>nr Easton Tal Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Louis S. Wetty</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Louis S. Wetty</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/24/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>SPRING HILL CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>EASTON, MARYLAND</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hampton Cawell</u>		ADDRESS <u>EASTON, MD.</u>	
24a. REC'D BY REGISTRAR <u>12/24/56</u>		24b. REGISTRAR'S SIGNATURE <u>N.H. Newell</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



ALBANY STATE DEPARTMENT OF HEALTH - BUREAU OF  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

EC - 1036

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 Item 7 Film G208 12-28-56 et  
 12947  
 CERTIFICATE OF DEATH

12931  
 291

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>TALBOT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>TALBOT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MICHAEL'S</u>				c. LENGTH OF STAY IN 1b <u>28 years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>—</u>				d. STREET ADDRESS <u>122 Dodson Ave.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>PAULINE WILLIAMS</u>				4. DATE OF DEATH Month Day Year <u>DEC. 20 1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>COLORED</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 26 1896</u>	
9. AGE (In years lost birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OYSTER SHUCKER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SEAFOOD</u>		11. BIRTHPLACE (State or foreign country) <u>ST. MARYS Co, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Maddox</u>				14. MOTHER'S MAIDEN NAME <u>AGNES COONES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Edgar Williams, St. Michaels Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Alcoholism</u> <u>322.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1926</u> , to <u>20 Dec 1956</u> , that I last saw the deceased alive on <u>20 December 1956</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. Lane Worth</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Box 487 St. Michaels, Md 12-21-56</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/24/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Aloysius Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Leonardtown, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>St. Ambrose Harrison</u>				ADDRESS <u>St. Michaels Md</u>		24a. REC'D BY REGISTRAR DATE <u>12-22-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Mrs. Robert L. Scott</u>			



CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES M. JONES		2. SEX Male		3. AGE 35	
4. DATE OF DEATH Dec 28 1956		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. PLACE OF BIRTH Baltimore, Md.	
10. OCCUPATION Teacher		11. MARITAL STATUS Married		12. EDUCATION High School	
13. PREVIOUS ILLNESS None		14. MEDICAL HISTORY None		15. SIGNATURE OF PHYSICIAN J. M. Jones	
16. SIGNATURE OF WITNESS J. M. Jones		17. SIGNATURE OF DECEASED J. M. Jones		18. SIGNATURE OF REGISTRAR J. M. Jones	

BUREAU V. 1

DEC 28 1956

RECEIVED



12932  
240

Reg. Dist. No. 240

1. PLACE OF DEATH  
a. COUNTY Talbot MARYLAND  
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton  
c. LENGTH OF STAY IN 1b  
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)  
a. STATE Maryland b. COUNTY Talbot  
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels  
d. STREET ADDRESS  
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First Middle Last  
Francis C. Wrightson  
4. DATE OF DEATH Month Day Year  
Dec 23 19 56

5. SEX M 6. COLOR OR RACE W 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐  
8. DATE OF BIRTH Sept. 25, 1883 9. AGE (In years last birthday) 73 yrs.  
IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
10b. KIND OF BUSINESS OR INDUSTRY  
11. BIRTHPLACE (State or foreign country) Maryland  
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Francis C. Wrightson  
14. MOTHER'S MAIDEN NAME Anna Rebecca Dawson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)  
16. SOCIAL SECURITY NO.  
17. INFORMANT Mrs. Medred Wrightson Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  
PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) 825X Pulmonary embolism  
DUE TO (b) sudden  
DUE TO (c)  
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)  
Fractured spine - lumbar

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.  
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto accident  
20c. TIME OF INJURY Month, Day, Year Hour - m. a. m. p. m. 11-21- 19 56  
20d. INJURY OCCURRED While at work ☐ Not while at work ☐  
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway 300  
20f. (City or town) (County) (State)  
Kenton Kent Delaware

21. I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☐ Inquiry ☐ and find that death resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined cause ☐.

ACTUAL SIGNATURE Thurston Harrison M.D. CHIEF MEDICAL EXAMINER ☐  
EXAMINER'S NAME (Type) THURSTON HARRISON ASSISTANT MEDICAL EXAMINER ☒  
DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED 23 Dec 56

22a. BURIAL, CREMATION, REMOVAL (Specify) Dec 26, 56 22b. DATE THEREOF  
22c. NAME OF CEMETERY OR CREMATORY Spring Hill 22d. LOCATION (City, town or county) (State)  
Spring Hill Easton MD

23. FUNERAL DIRECTOR'S SIGNATURE Walter G. Gentry, Jr. 24a. REC'D BY REGISTRAR 12/26/56 24b. REGISTRAR'S SIGNATURE W. A. Perkins

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



STATE OF NEW YORK  
DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH a. COUNTY <u>Talbot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Trappe Rural</u>		c. LENGTH OF STAY IN 1b <u>3 Mo. 21 da</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>Trappe, Rural</u>	
3. NAME OF DECEASED (Type or print) First <u>Donald</u> Middle <u>Gilbert</u> Last <u>Young</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>6</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>black</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 15-1956</u>
9. AGE (In years last birthday) yrs. <u>3</u>		IF UNDER 1 YEAR: Months <u>3</u> Days <u>21</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Eastern Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Herman Young</u>		14. MOTHER'S MAIDEN NAME <u>Beatrice Young</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Herman Young, Trappe Rural, Md.</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X</u> DUE TO <u>Bacterial pneumonia</u> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (c) <u></u> DUE TO <u></u> DUE TO <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u></u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov 6</u> , 19 <u>56</u> to <u>Nov 6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov 6</u> , 19 <u>56</u> , and that death occurred at <u>7:15 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Hayward H. H. H.</u> M.D.		ADDRESS (Street, city or town, state) <u>Eastern, Md.</u> DATE SIGNED <u></u>	
PHYSICIAN'S NAME (Type) <u>M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec 8/1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Tyoutown Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Eastern Rural Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John R. Williams</u> ADDRESS <u>Eastern Md.</u>		24a. REC'D BY REGISTRAR <u></u> DATE <u>12/8/56</u>	24b. REGISTRAR'S SIGNATURE <u>N.H. Newen</u>

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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